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Language Modality for Deaf or Hard of Hearing Preschoolers: Maine Parents' Decision-Making

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LANGUAGE MODALITY FOR DEAF OR HARD OF HEARING PRESCHOOLERS: MAINE PARENTS' DECISION-MAKING

by

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ABSTRACT

Both parental decision-making and the choice of language modality for Deaf and Hard of Hearing (DHH) children have been studied. In investigating the two subjects in conjunction with a bilingual bimodal (bi-bi) program, however, there is an apparent lack of research. A preschool program featuring bi-bi in Maine, named the Maine Educational Center for the Deaf and Hard of Hearing (MECDHH), prides itself on the fact that parents determine their child's primary language upon enrollment. Although many bi-bi programs exist worldwide, the MECDHH program is unique in that the preschoolers are separated into two different classrooms: one featuring solely orally expressed English instruction, and the other featuring strictly ASL instruction. In the present study, a survey was distributed to parents of MECDHH's preschool program asking them to identify the various factors that had the greatest impact on the educational decisions for their child. The study found that the most important factors involved in decision-making for this group of parents included "future goals for my child" "my child's hearing status", and "professional advice".

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INTRODUCTION

Parents have both rights and obligations in making decisions for the wellbeing of their children. Parent decision-making, in general, is complicated due to the lack of an overarching "correct" answer for each family. The fact that parents face tough decisions in raising children holds true for parents of deaf children as well. These parents face some unique choices which parents of hearing children may never need to consider, such as the type of amplification to pursue, the best educational path to embark upon, and, especially, the language their child will use. In the general US population, about 2.1% of people are deaf or hard of hearing (DHH), and in Maine, the deaf population makes up about 3.1% of the total population (Deaf Statistics, n.d.). According to these values, Maine is tied to be ranked as the state with the third highest DHH population percentage following West Virginia and Alaska (States Ranked by Size & Population, n.d.). This represents quite a large population for whom educational decisions must be made. Due to a lack in literature regarding how parents choose the best language modality and educational placement for their child in a bilingual bimodal (bi-bi) program featuring separate classrooms, a study has been proposed. This thesis reviews the literature on the delivery of interventional information, various educational options such as bi-bi, DHH parental decision making, and concludes with a study which aims to survey DHH preschool parents in Maine on the most influential factors behind their selection of various options.

Timeframe and Stress

Many of the necessary decisions to be made present themselves at a time when parents are likely to be experiencing heightened emotions. Upon diagnosis, families have

experienced feelings of denial, anger, guilt, and even grief (Flaherty, 2015), and contemplating important decisions in an altered state of mind further complicates the process. Since 95% of children with a hearing loss are born without deaf relatives, "hearing parents with a recently diagnosed deaf child generally find themselves negotiating a world previously unknown" (Hyde, Punch, & Komesaroff, 2010, p. 163). Wemm and Wulfert (2017) explain that stress and decision making both influence each other: stress can affect the way a decision is made, and decision making in turn can cause stress. In a study examining the relationship between stress and decision making, the authors noted that the stressed individuals, as compared to their control group counterparts, took longer to gather information about options relating to the decision (Preston, Stansfield, Buchanan, & Bechara, 2007).

In addition, parents must consider the fact that many of the necessary decisions are of a time sensitive nature. For instance, even the timeline surrounding the diagnosis of a hearing loss is quite scheduled. According to recommended guidelines from the federal Joint Committee on Infant Hearing (2007), early identification programs must follow a "1-3-6" guideline for all newborns who failed an initial screening. By one month of age, a child should be screened, and three months of age is the goal for a diagnostic hearing evaluation. Once the diagnostic hearing evaluation approaches, federal guidelines call for a referral to an early intervention program following any type of diagnosed hearing loss. Preferably, audiologists should make a referral within two days of their findings in order to begin the intervention process as soon as possible. At six months of age, the child should begin working with the early intervention program. The push for a timely diagnostic process is in effect due to the importance of early language acquisition and

obtaining communicative competence. Each child goes through a particularly sensitive period, termed the critical period, in which the presence of language learning is essential (Friedmann & Rusou, 2015). Regardless of the modality, every child needs to have access to language learning during the early stages of life. During the critical period, which has yet to be numerically defined, the natural acquisition of a language occurs through exposure. Various studies have proven that a deprivation of exposure to language during the critical period is detrimental to syntactical development (Friedmann & Rusou, 2015). For this reason, it is not only important, but crucial, that the child be exposed to language of some form early in his or her life (Mellon, et al., 2014), and that parents address important decisions promptly to facilitate the outcomes they desire for their children.

Limited Options

Historically, parents had a limited number of options relating to their child's education. Typically, deaf students would be sent to a residential school to live in dormitories. Often, a child would be separated from his/her family around the age of three to begin school (Gilliam & Easterbrooks, 1997). Residential schools are still in practice, but Deaf education has since varied the options available to children in terms of the setting, educational philosophy and the instructional mode. The debate between instructional mode of DHH students has been ongoing for hundreds of years (Nordstrom, 1986), and curriculums have been redesigned to adhere to all types of needs. American Sign Language (ASL), Auditory-Oral, Cued Speech, Total Communication, and Bilingual-bimodal (bi-bi) have all been featured in Deaf education (Gravel & O'Gara, 2003).

Advancements in amplification, assistive technologies, and acoustical design have all impacted the students' ability to learn in a classroom. In this type of setting, the signal-to-noise ratio (SNR) rationalizes the sound level of a teacher's voice compared to the background noise of the classroom, and a positive SNR relates to higher speech intelligibility and comprehension (Classroom Acoustics, n.d.). Frequency modulation (FM) systems offer the DHH student a closer relationship, acoustically, to the teacher or speaker. These systems consist of a transmitter, to be worn by the teacher, and a receiver connected to the student's hearing aid. An FM system creates the illusion that a teacher can speak in the child's ear from across the classroom. The SNR can be up to 30 dBA while using an FM system (Turan, 2007). Due to these advances, parents now have the option to mainstream their child into a hearing classroom. Since the invention of hearing aids and cochlear implants, the trends in deaf school enrollment have steadily decreased as parents decided to place their child in a mainstream environment (Holmstrom & Schonstrom, 2017). These mainstream classrooms usually feature small class sizes, child-specific hearing equipment, and hearing pedagogues (Holmstrom & Schonstrom, 2017).

Bi-Bi

The bilingual-bimodal philosophy of deaf education is founded from the two terms in its namesake: being both bilingual and bimodal. Bilingualism is the ability to use two distinct languages successfully, and bimodal refers to the ability to use a range of signed, spoken, and written languages (Swanwick, 2015). English and American Sign Language are composed of two polar rule sets of grammar and syntax, so being competent in both forms of language would classify a language learner as bilingual bimodal. To gain communicative competence, the student must practice a primary

language (L1) upon which a language base is established. The bi-bi approach is "additive", meaning it "builds upon a child's strength in one language while adding a second language" (Nussbaum, Scott, & Simms, 2012, p. 16). A second language will flourish along with the continuation of the primary language. Since the critical period calls for fast and clear language within the first five years of a child's life, it is suggested that deaf children use ASL as their first language (Nussbaum, Scott, & Simms, 2012). "ASL is an efficient language for visual learning and is easier for Deaf children to acquire as a first language than any other form of English" (Baker & Baker, 1997, p. 3). The efficacy of bilingual bimodal programs has been studied by a limited number of researchers. The results have shown to exhibit academic growth and increased literacy abilities among children in bi-bi settings. In a doctoral dissertation, Geeslin (2007) studied the academic performance of 182 students of the Indiana School for the Deaf before and after the implementation of a bi-bi approach. The participants were separated into pre-implementation and post-implementation groups, then the exam scores of the students were further separated into their "younger" and "older" years. The findings showed that the younger groups both pre- and post-implementation of bi-bi scored similarly in academic performance. The academic performance of the older group, however, showed that the group using bi-bi strongly outperformed the group that attended the same school before bi-bi was implemented (Geeslin, 2007). Lange et al. showed similar results (2013). The authors researched the "longitudinal reading and mathematics achievement results of deaf students compared with their national grade-level and achievement-level peers" (p. 534) from Metro Deaf School in Minnesota. 315 students from the Metro Deaf School were compared to scores of over 2.8 million

students from the Northwest Evaluation Association. The findings showed that the beginning growth level of the deaf students in the bi-bi program was significantly lower than the growth of the national average. Over time, though, the deaf students met and exceeded the academic growth levels of the comparison group. The academic achievement of deaf students supports the efficacy of the bi-bi instructional model (Lange, Lane-Outlaw, Lange, & Sherwood, 2013).

Acquiring Information

Many factors are considered when families determine the appropriate educational services for their DHH child. Families recruit information from various resources like health care professionals, friends, family and the internet. The Joint Committee on Infant Hearing (2007) recommends that early intervention programs inform families of the resources available in their area. Opportunities to meet with other DHH children, DHH adults, and families should be provided. Also, the parents should be supplied with general, professional, and educational information on their child's specific type of hearing loss and the options that will soon follow (Joint Committee on Infant Hearing, 2007). As an example of a resource offered to DHH families, in Colorado, the Colorado School for the Deaf and the Blind offers services through individuals termed "CO-Hears" (Services Provided by CO-Hears, n.d.). These guides act as the family's assistant in providing their DHH child with the most suitable resources. CO-Hears discuss communication options, offer support, and connect parents with other families. They even join Individualized Family Services Plan meetings (Services Provided by CO-Hears, n.d.). CO-Hears are available to all families with DHH children under age 3 (Services Provided by CO-Hears, n.d.). In Maine, an important resource for families is the Maine

Newborn Hearing Program. This source provides therapeutic and educational pamphlets about all the stages of raising a DHH child (Maine Newborn Hearing Program, n.d.). Another opportunity for support and education comes from the group called Maine Hands and Voices (Maine Hands & Voices, n.d.). This parent-run non-profit organization offers unbiased support in providing families with resources and networks to explore communication options (Maine Hands & Voices, n.d.).

An acrimonious debate between proponents of different language modalities has spanned centuries and leads to information sources filled with opinions, attitudes, and bias (White, 2017). *The Journal of Deaf Studies and Deaf Education* published an article in 2010 in which the parental responses relating to a cochlear implantation decision could closely relate to language modality. The authors explain that due to the lack of definitive outcome data, "parents must make decisions without any guarantees about the level of benefit their children will receive" (Hyde, Punch, & Komesaroff, 2010, p. 165), which further emphasizes the importance of information seeking. Each method of communicating encompasses both benefits and limitations, and longitudinal studies have shown skewed results.

Hardonk, et al. (2010) conducted a survey regarding a parent's decision to implant their child with a cochlear implant. The authors classified the influencing decision making aspects into eight categories: referral and professional advice, biomedical aspects, ethics, information and knowledge about care and rehabilitation, earlier experiences with deafness, social support, information-seeking behavior, and cost-related aspects (Hardonk, et al., 2010). Although these categories of factors are intended to decipher cochlear implantation decision making, most of these categories can also relate to

educational and communication modality decision making. A similar study examined the types of information used when making the decision to implant their child, and the results showed the use of audiologists, ear nose and throat specialists, pediatricians, DHH adults, DHH children, and other families with DHH members, early intervention centers, literature, the internet, and, finally, their own family members (Hyde et al, 2010).

The Li et al. (2003) study surveyed parents regarding their decision in determining a language modality for their DHH child. Given the options of using information from a professional and from a friend, 90% of respondents found the recommendation from a professional to be the most important factor (Li, Bain, & Steinberg, 2003). In a similar study, Decker et al. (2012) surveyed parents on the most influential factors in determining a communication method. Contrary to the findings of the 2003 study, (Li, Bain, & Steinberg, 2003), Decker, Vallotton, and Johnson found that 86% of parent responses favored the option "my own judgement" over the information given from medication professionals, family members, teachers, etc. (Decker, Vallotton, & Johnson, 2012). Another finding of this study related to the quantity of sources received. Parents reported receiving four sources of information, but only found two of those sources influential (Decker, Vallotton, & Johnson, 2012). Also noteworthy is the authors' comparison between the decided communication modality and the sources of information. The authors conclude, "parents who chose to use speech received information from teachers or school personnel and audiologists or speech pathologists more often than those who chose to use a method that included signs" (Decker, Vallotton, & Johnson, 2012, p. 335).

In a time that information is so readily accessible through the use of smart phones, it is important to consider the effect of the internet in the gathering of information. Porter and Edirippulige's study (2007) surveyed 166 Australian parents of DHH kids and their likelihood to use the internet as a source of information on hearing loss. The results found that 67% of parents were very comfortable using the internet as a source of information. In fact, over 50% of the respondents used the world wide web to access information from online support groups (Porter & Edirippulige, 2007).

It is important that professionals be mindful of the way information is being translated to the parent. The audiologist is often the first professional that a parent will visit regarding their baby's recently diagnosed hearing loss. It is the audiologist's responsibility to facilitate an easy transition to the EHDI team for the family (National Center for Hearing Assessment and Management Utah State University, 2017). Relating back to the fact that hearing loss is a foreign subject to most parents, the audiologist must take on a therapeutic approach in guiding the family. In order to implement proper care, clinicians need to have skill on how to properly counsel the psychosocial aspect of the diagnosis' effect on the patient and the family (English, Mendel, Rojeski, & Hornak, 2008). "If the audiologist is insensitive to the emotions being experienced by the family and concentrates on delivering only factual information, the family may withdraw from the entire process" (National Center for Hearing Assessment and Management Utah State University, 2017, p. 2). A tactic to help audiologists clarify the diagnosis and available options for parents is by translating professional jargon into clear and familiar vocabulary.

MECDHH

In Maine, the only school dedicated to educating DHH children is Governor Baxter School for the Deaf/Maine Educational Center for the Deaf and Hard of Hearing (MECDHH). The educational goals of the preschool are met by following a bilingual-bimodal (bi-bi) philosophy. In order for the school to be in accordance with this model, the preschool is divided into two classrooms: an American Sign Language (ASL) room, and an oral room. Although the lesson plans and daily activities are identical, the instructional modality differs between the rooms. The teachers in the ASL room use strictly ASL with the children while the teachers in the oral room only communicate using "spoken English". Although a child will not be reprimanded for using an alternative modality than the one assigned to the classroom, accordance with the specific modality of the teacher is strongly encouraged (Hopkins, 2017). The division of the program means the parent must assign a "primary" language for their child. In the context of bi-bi education, the primary language is the language in which a child gains communicative competence. A solid foundation in the primary language will lead to high proficiency in the secondary language (Baker & Baker, 1997). MECDHH prides themselves in the fact that parents determine their child's primary language upon enrollment (Preschool, n.d.). Although many bi-bi programs exist worldwide, the MECDHH program is unique in that the preschoolers are separated into two separate classrooms: one featuring solely orally expressed English instruction, and the other featuring strictly ASL instruction. The idea of this separation revolves around the ideal for the children to learn how to act and communicate when using both English and ASL modalities. The director of early

childhood education and family services, Karen Hopkins, proves the school's productivity by stating that 90% of their preschoolers passed the kindergarten screening. She went on to explain that the 10% who did not pass had additional developmental disabilities (Hopkins, Karen, 2017). Hopkins further discusses the decision of a primary language by explaining that the IEP team regularly assesses the child's capabilities and needs based on both formal and informal measures (Hopkins, 2017), but the final classroom decision is left in the hands of the parent. While quality research exists investigating the efficacy of a bi-bi agenda, there is a gap in the literature about the parent's decision of assigning a primary language.

METHOD

The proposed study involves a survey that will be implemented to parents of MECDHH's preschool program and will ask the parent to identify the various factors that had the greatest impact on their ultimate decision of the primary communication modality for their DHH preschool aged child. The intention of this study is to explore the factors influencing the Maine parent's decision of choosing a primary language in a bi-bi program. Using an online survey, consenting parents will answer various questions pertaining to their child's diagnosis and the factors that were considered before they came to decide between the spoken English or the American Sign Language classroom at the Maine Educational Center for the Deaf and Hard of Hearing. The online survey will be administered through Qualtrics.com, a survey instrument software. The full survey is provided in appendix A.

Participants

Participants will be recruited from parents of the current roster of the Maine Educational Center for the Deaf and Hard of Hearing preschool program. Parents, of all hearing abilities, of children diagnosed with a hearing loss will be asked to enroll in the current research study. The letter and survey link sent to the director of MECDHH's early childhood and family services will be sent to the all the parents in the preschool program.

Procedures

Along with proof that the current study was approved by the University of Maine's Institutional Review Board, MECDHH will be provided with a letter written by the principal investigator inviting parents of the preschool children to participate in a

research study. The director of early childhood and family services at MECDHH will deliver the invitation to all the parents who qualify to participate. The letter to the parent will include an explanation of the aims of the study along with a statement of the risks and benefits associated with participation in the study. Parents will be required to electronically consent to participate. The survey will take each parent about 5 minutes to complete, and will consist of various multiple choice questions. For example, a question on the survey could ask, “Besides recommendations from school personnel, which factors most influenced your decision to place your child in the Spoken English classroom? Please choose 3”. The parent will be asked to select three from a list of twelve responses. At the end of the survey, parents will be given the opportunity to expand on some of the responses given.

RESULTS

At last count, the preschool program at MECDHH enrolled 20 children. In the present study, 13 parents responded on behalf of their children. Five children are three years old (38.46%). Six children are four years old (46.15%), and 2 children are five years old (15.38%). As reported by the parents, all the children of the respondents have been diagnosed with a bilateral hearing loss. The losses range from mild to profound with the majority diagnosed as profound (n=6) (46.15%), followed by severe at 30.77% (n=4). About 23.08% (n=3) of the children are diagnosed with a mild-moderate hearing loss. In response to such losses, children of the respondents use a variety of amplification methods and interventional technology including hearing aids (n=6) (46.15%), cochlear implants (n=4) (30.77%), bone anchored hearing aids (BAHA) (n=1) (7.69%) as well as no amplification (n=2) (15.38%). Table 1 includes basic demographic information of the children included in this study.

Table 1. Basic demographic information of children.

How old is your child?		
Three 5 (38.46%)	Four 6 (46.15%)	Five 2 (15.38%)
Is your child's hearing loss unilateral or bilateral?		
Unilateral 0 (0%)	Bilateral 13 (100%)	
What is the degree of your child's hearing loss?		
Mild-Moderate 3 (23.08%)	Severe 4 (30.77%)	Profound 6 (46.15%)
What amplification does your child use?		

Hearing Aid	Cochlear Implant	BAHA	None
6 (46.15%)	4 (30.77%)	1 (7.69%)	2 (15.38%)

The parents were asked the level of interaction they experienced with a Deaf individual besides their child when they first enrolled their child at MECDHH. The extent of interaction that families experienced with deaf individuals ranged from never to all the time. Forty-six percent of participants (n=6) indicated that they never interacted with a DHH individual. Thirty-eight percent (n=5) answered about one hour per week, and 15.38% (n=2) responded with "all the time" to the question of Deaf interaction experience. In response to a question about the primary classroom their child was initially placed in, two (15.38%) responded with American Sign Language Room while 11

(84.62%) answered Spoken English Room. The responses to Deaf interaction levels and initial classroom placement can be found in Table 2.

Table 2. Deaf interaction and initial classroom placement responses.

When you first came to MECDHH, how often did you interact with a Deaf individual other than your child?		
Never 6 (46.15%)	1 hour/week 5 (38.46%)	All the time 2 (15.38%)
When your child was first enrolled at MECDHH, which room was his/her primary classroom?		
American Sign Language Room 2 (15.38%)	Spoken English Room 11 (84.62%)	

The parents (n=2) who responded with American Sign Language as their child's primary classroom were asked to choose three factors that influenced their classroom placement decision. Both parents listed "my child's hearing status" and "I feel knowledgeable and experienced in ASL" as factors contributing to their decision. One parent also chose "fit for my child" while the other indicated "future goals for my child".

The parents (n=11) who responded with Spoken English Room as their child's primary classroom were asked the same task. When asked to choose three factors influencing their child's classroom placement decision, eight parents indicated that "future goals for my child" contributed to their decision making. Five parents responded with "professional advice (audiologist, speech-language pathologist, pediatrician, etc.)", five parents answered, "my child's hearing status", five replied "fit for my child", and

five answered, “communication at home”. One parent chose “other” and elaborated by explaining that their childhood friend was enrolled at the school at one point.

Over 30% of respondents (n=4) indicated that they had changed their child’s primary classroom placement at least once. They elaborated by explaining that their child uses half ASL and half spoken English, their child decided against amplification technology, or they saw positive results in the other classroom during “free time”. Sixty-nine percent of parents (n=9) had never changed their child’s primary classroom.

DISCUSSION

Interestingly, 11 (84.61%) parents reported to have minimal experience in interacting with Deaf individuals. This finding is somewhat consistent with the fact that 95% of DHH children are born without another DHH relative (Hyde, Punch, & Komesaroff, 2010). Of the two parents who indicated that they interacted with DHH individuals all the time, one parent chose to place their child in the ASL room and the other chose the Spoken English room. The parent who chose the Spoken English room notes that their child had a mild-moderate hearing loss and some important factors in their decision making were their child's hearing loss and future goals for their child. Although this parent may be knowledgeable and comfortable in communicating with DHH individuals, their child's degree of loss factored into the decision to place the child in the oral room. The parent who chose the ASL room, however, responded on behalf of a profoundly deaf child with no amplification technology. If this child experienced no benefit from amplification technology, the parent may have wanted the child to have as much access to ASL as possible. Additionally, the parent responded by saying that one of the most influential factors in their decision was the face that they felt knowledgeable and experienced in ASL. This may be the communication method at home.

Eight parents (61.54%) related their decision making to the future goals for their children. Again, since most DHH children are born without DHH relatives, parents of these young children are typically facing a decision they never planned to make. Although this survey never asked the parent to disclose their own hearing status, according to the 95% statistic, most of these parents will be hearing. If that is the case,

these parents may aspire for their child to be able to communicate and interact in a hearing world, which is all they have known.

An important fact to note is that no parents from the ASL room nor the Spoken English room selected "I did research on it" as a factor influencing their ultimate decision of their child's primary classroom placement, whereas five participants relied on advice from various professionals. These five respondents account for 38.46% of contribution for this survey. This percentage varies significantly from the 90% of respondents in a similar study who recorded professional advice as the most important factor in their decision making (Li, Bain, & Steinberg, 2003). This group of Maine parents' reliance on professionals is much lower than expected compared to the national Li et al. (2003) study.

In conclusion, about 70% of participants (n=9) said they had never changed their child's primary classroom placement. These nine respondents all had children on the younger side of the program. In fact, all the three year olds (n=5) have remained in the same classroom that they began in. All the five year olds (n=2) had switched primary classrooms at one point. The parents of the younger kids' tendency to keep the children in the same classroom could be in response to the child becoming accustomed to school functioning.

It's important to note that due to the small nature of this sample (n=13), generalizations cannot be made solely based on this study. Although this study rendered intriguing results, these parents represent a very small number in the community of DHH parents. To enhance a future study, the sample size would ideally be larger by a great factor. Additionally, a beneficial addition to the data would be to distribute the survey to

parents of older DHH students who have graduated from the MECDHH program. It would be interesting to see the differences from year-to-year of the parents of older generations. A report on the parent's point of view of how they felt during the decision versus how they felt about the decision years later could be beneficial to current parents facing the classroom placement decision.

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APPENDICES

APPENDIX A: SURVEY QUESTIONS

How old is your child?

- 3 years old
- 4 years old
- 5 years old

Is your child's hearing loss unilateral or bilateral?

- Unilateral
- Bilateral

What is the degree of your child's hearing loss?

- Mild-moderate
- Severe
- Profound

What amplification does your child use?

- Hearing aids
- BAHA
- Cochlear Implants
- None

When you first came to MECDHH, how often did you interact with a deaf individual other than your child?

- Never
- 1 hour/week
- 10 hours/week

- All the time

When your child was first enrolled at MECDHH, which room was his/her primary classroom?

- American Sign Language Room
- Spoken English Room

Besides recommendations from school personnel, which factors most influenced your decision to place your child in the ASL classroom? Please choose 3.

- I know kids in the class
- Recommendation from family/friend
- Communication at home
- Teacher preference
- I did research on it
- Future goals for my child
- Professional advice (audiologist, speech pathologist, pediatrician etc.)
- I feel knowledgeable and experienced in ASL
- I don't know/I forgot
- My child's hearing status
- Fit for my child
- Other _____

Besides recommendations from school personnel, which factors most influenced your decision to place your child in the Spoken English classroom? Please choose 3.

- I know kids in the class
- Recommendation from family/friend
- Communication at home
- Teacher preference
- I did research on it
- Future goals for my child

- Professional advice (audiologist, speech pathologist, pediatrician etc.)
- I do not feel knowledgeable and experienced in ASL
- I don't know/I forgot
- My child's hearing status
- Fit for my child
- Other _____

Have you ever changed your child's primary classroom?

- Yes
- No

Please discuss the reasoning behind switching classrooms.

APPENDIX B: IRB APPROVAL LETTER

☆ **Paula Portalatin** Inbox - sara...uez@maine.edu February 23, 2018 at 9:04 AM

IRB application 2018-02-07 - Approval Details

To: Sarah Basquez, Cc: Nancy Hall, amy_booth@umit.maine.edu

RE: A Maine parent's decision regarding primary language modality for their deaf/hard of hearing child in a bilingual/bimodal classroom

Dear Sarah,
The study referenced above has final approval to begin. The study was judged exempt from further review under Category 2 of the regulations. As a study in that category, no further communication with the IRB is required, unless you need a modification.

We keep applications in this category for five years and then destroy, but we will confirm with you that the study is completed prior to destroying.

I have attached the completed cover page and approved application for your records.

If you need to submit a modification to the study please visit our website at:
https://umaine.edu/research/faculty/research-compliance/institutional-review-board-for-the-protection-of-human-subjects-irb/modify-approved-study/

Good luck with the study.

Best regards,
Paula

--

Paula Portalatin, M. Ed., CPIA
Research Compliance Officer II
Office of Research Compliance
University of Maine
Room 402 Corbett Hall
Orono, Maine 04469-5717
(207) 581-2657

APPLICATION COVER PAGE

- ***KEEP THIS PAGE AS ONE PAGE – DO NOT CHANGE MARGINS/FONTS!!!!!!!!!***
- ***PLEASE SUBMIT THIS PAGE AS WORD DOCUMENT***

APPLICATION FOR APPROVAL OF RESEARCH WITH HUMAN SUBJECTS
Protection of Human Subjects Review Board, 400 Corbett Hall

(Type inside gray areas)
PRINCIPAL INVESTIGATOR: Sarah Basquez **EMAIL:** sarah.basquez@maine.edu
CO-INVESTIGATOR: **EMAIL:**
CO-INVESTIGATOR: **EMAIL:**
FACULTY SPONSOR: Nancy Hall/Amy Booth **EMAIL:** nhall@maine.edu / amy_booth@umit.maine.edu
(Required if PI is a student):
TITLE OF PROJECT: A Maine parent's decision regarding primary language modality for their Deaf/Hard of Hearing Child in a Bilingual/Bimodal Classroom
START DATE: February 2018 **PI DEPARTMENT:** Communication Sciences and Disorders
FUNDING AGENCY (if any):

STATUS OF PI: FACULTY/STAFF/GRADUATE/UNDERGRADUATE U (F,S,G,U)

1. If PI is a student, is this research to be performed:

- ☒ for an honors thesis/senior thesis/capstone?
- ☐ for a master's thesis?
- ☐ for a doctoral dissertation?
- ☐ for a course project?
- ☐ other (specify)

2. Does this application modify a previously approved project? N (Y/N). If yes, please give assigned number (if known) of previously approved project:

3. Is an expedited review requested? Y (Y/N).

Submitting the application indicates the principal investigator's agreement to abide by the responsibilities outlined in Section I.E. of the Policies and Procedures for the Protection of Human Subjects.

Faculty Sponsors are responsible for oversight of research conducted by their students. The Faculty Sponsor ensures that he/she has read the application and that the conduct of such research will be in accordance with the University of Maine's Policies and Procedures for the Protection of Human Subjects of Research. REMINDER: if the principal investigator is an undergraduate student, the Faculty Sponsor MUST submit the application to the IRB.

Email this cover page and complete application to UMRIC@maine.edu

****

FOR IRB USE ONLY Application # 2018-02-07 Review (F/E): E Expedited Category:
ACTION TAKEN:

- X☐ **Judged Exempt; category 2 Modifications required? Yes Accepted (date) 2/16/2018**
- ☐ **Approved as submitted. Date of next review: by Degree of Risk:**
- ☐ **Approved pending modifications. Date of next review: by Degree of Risk:**
  Modifications accepted (date):
- ☐ **Not approved (see attached statement)**
- ☐ **Judged not research with human subjects**

FINAL APPROVAL TO BEGIN **2/16/2018**
Date

01/2017

APPENDIX C: INFORMED CONSENT

Purpose

You are invited to participate in a research project being conducted by Sarah Basquez, an undergraduate student in the Department of Communication Sciences and Disorders at the University of Maine. The faculty sponsors are Dr. Nancy Hall and professor Amy Booth, both from the department of Communication Sciences and Disorders at the University of Maine. The purpose of the research is to investigate the factors leading to a Maine parent's decision for the educational placement of the Deaf/Hard of Hearing child in a bilingual-bimodal program. You must be at least 18 years of age to participate.

What will you be asked to do?

If you decide to participate, you will be asked to complete an anonymous survey. The questions will be related to the most important factors in deciding an educational plan for your child. At the end, you will be asked to elaborate on your experience in determining a classroom for your child. It may take approximately 5 minutes to participate.

Risks

There is the possibility that you may become uncomfortable answering the questions. You may skip and questions you prefer not to answer.

Benefits

While this study will have no direct benefit to you, this research may help us learn more about the factors that parents value most in making educational decisions for their

child. In addition, the study may become a resource for the next generation of parents of Deaf/Hard of Hearing children at MECDHH and many similar schools.

Confidentiality

All your responses will be anonymous. Information from Qualtrics will be deleted in August 2018. Participation is voluntary. If you choose to take part in this study, you may stop at any time. You may skip any questions you do not wish to answer. Return/submission of the survey implies consent to participate.

Voluntary

Participation is voluntary. If you choose to take part in this study, you may stop at any time. You may skip any questions you do not wish to answer.

Contact Information

If you have any questions about this study, please contact me at (207) 522-2701, 37 Cushnoc Ln, Brunswick, ME 04011, sarah.basquez@maine.edu. You may also reach the faculty advisor on this study at (nhall@maine.edu) (amy_booth@umit.maine.edu). If you have any questions about your rights as a research participant, please contact Gayle Jones, Assistant to the University of Maine's Protection of Human Subjects Review Board, at 581-1498 (or email gayle.jones@umit.maine.edu).

Your selecting the link below indicates that you have read the above information and agree to participate.

AUTHOR'S BIOGRAPHY

Sarah Basquez is from Brunswick, Maine, and graduated from Brunswick High School in 2014. Sarah spends summers at the lake in Damariscotta, Maine, as well as working as Dockmaster at Strout's Point Wharf Company in South Freeport, Maine. At the University of Maine, Sarah majored in Communication Sciences and Disorders while she obtained a minor in Child Development and Family Relations. In her college years, Sarah was on the cheerleading team, acted as a Black Bear Mentor, worked for UMaine's athletic department, and volunteered at the Maine Educational Center for the Deaf and Hard of Hearing. She was also a member of the National Student Speech Language Hearing Association, secretary of the Latin American Student Organization and vice president of the Student Academy of Audiology. After graduating, Sarah will attend the University of Connecticut where she will pursue her Doctorate of Audiology degree. She hopes to serve the pediatric population in southern Maine once she becomes an audiologist.